Wye Valley NHS Trust

RLQ

Community health inpatient services

Quality Report

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Date of inspection visit: 22, 23 and 24 September 2015
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/unit/ team)
RLQ03	Bromyard Community Hospital		
RLQ06	Leominster Community Hospital	<Placeholder text>	<Placeholder text>
RLQ08	Ross Community Hospital	<Placeholder text>	<Placeholder text>
RLQ14	Hillside Intermediate Care Centre	<Placeholder text>	<Placeholder text>

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

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

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

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Overall summary

Overall rating for this core service Requires Improvement l

Overall, we found that:

There was limited evidence all relevant investigations and risk factors were considered when reviewing incidents. Safeguarding training data provided by the trust demonstrated that 52% of community inpatient staff had received appropriate training. Systems, processes and standard operating procedures were not always reliable or appropriate to keep patients safe. Checks on fridge and room temperatures where medicines were stored varied, and checks on medication that had stricter legal requirements were inconsistent. Nursing audits identified community inpatient staff did not always complete relevant assessments appropriately. Where staff had identified risks through an assessment, they had not always put in place relevant management plans. The trust was actively trying to ensure there were sufficient numbers of staff in the community hospitals. However, we were not confident appropriate action was taken to ensure an appropriate skill mix maintained the needs of patients and keep them safe. Staff did not fully recognise, assess or manage the risks associated with anticipated events and emergencies.

Care and treatment did not always reflect current evidence-based guidance, standards and best practice. Care assessments did not consider the full range of patients' needs, in particular pain management. There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. There were inconsistencies in staff maintaining competencies and developing their roles through additional training. There was no assurance regarding the revalidation and appraisal for the GPs providing medical cover at the community hospitals. Completed records were inconsistent in relation to when a mental capacity assessment was completed.

Patients and relatives informed us staff did not always involve them in their care or that of their loved one, particularly discharge planning.

When planning services, local population needs were not always fully understood or taken into account. Access to the therapy services was not always available in line with the patient's individual needs. Records demonstrated there was limited learning across the sites from complaints and concerns.

There was no strategy for the community inpatient service to support the vision of the trust. The arrangements for governance and performance management did not always operate effectively. There were inconsistent practices in place across the community hospitals and some documents in use were not ratified through the governance process. Not all leaders took part in all aspects of service development. There was mixed staff satisfaction. Staff did not always feel actively engaged and that they were part of one trust. The approach to service delivery and improvement was reactive and focused on short-term issues. Staff did not always identify improvements to ensure the trust sustained safe, quality care.

Staff were knowledgeable about incident reporting and the new duty of candour regulation (being open and honest with patients and relatives, as appropriate).

Relevant staff were included in the assessment, planning and delivering of patient care and treatment and GPs were able to access patient results from the trust's electronic reporting system. Staff had a good awareness of the Mental Capacity Act 2005 (MCA) assessments and Deprivation of Liberty Safeguards (DoLS).

Patients and relatives were positive about the way staff treated them. Staff treated patients with dignity, respect and kindness. Staff helped patients and those close to them to cope emotionally with their care and treatment. Patients were supported and encouraged to manage their own health and care when they could, to maintain their independence.

Staff were aware of specific needs individual patients had and were able to put in place appropriate arrangements, where possible. Staff were knowledgeable about the complaints process and what action they would take.

Risks and issues described by staff corresponded to those reported and were understood by leaders. Leaders were clear of their roles and accountabilities.

Summary of findings

Background to the service

Information about the service

Wye Valley NHS Trust provides community services and hospital care to a population of slightly more than 180,000 people in Herefordshire and provides urgent and elective care to a population of more than 40,000 people in mid Powys, Wales.

The trust has four community hospitals, which provide inpatient services. These are Bromyard Community Hospital, Hillside Intermediate Care Centre, Leominster Community Hospital and Ross Community Hospital. The inpatient services provided are predominately rehabilitation, with patients transferred from Hereford Hospital. There are 98 community inpatient beds.

The community inpatient services are managed under the Urgent Care and Care Closer to Home service management team.

The community hospitals are predominately nurse led. The medical cover for each of the four community hospitals varies and includes support from primary care. At Ross Community Hospital, a full time senior house officer (SHO) provides cover, with support from a local GP practice. The SHO is on site Monday to Friday. A GP is based on site at Leominster Community Hospital for five hours a day, Monday to Friday. The out-of-hours service is provided by GPs employed by Primecare under a service level agreement (SLA).

Primary care services provider Primecare also provides medical cover at Hillside Intermediate Care Centre, both in and out of core service hours. The patients at Bromyard Community Hospital are managed by a local GP practice, both in and out of core service hours.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Turkington, Medical Director, Salford Royal NHS Foundation Trust

Team Leader: Helen Richardson, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including a consultant geriatrician, a community therapist and a senior medicine nurse.

Why we carried out this inspection

We inspected this core service as part of our planned comprehensive inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before we visited the four community hospitals (part of Wye Valley NHS Trust), we reviewed a range of information we hold about the community inpatient service and asked other organisations to share what they knew. We carried out an announced visit on 22, 23 and 24 September 2015. During the visit, we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with patients and

Summary of findings

observed how patients were being cared for. We talked with carers and family members and reviewed care or treatment records of patients. We met with patients and carers, who shared their views and experiences of the core service.

What people who use the provider say

The 2015 Patient-Led Assessment of the Care Environment (PLACE) survey score for privacy, dignity and wellbeing had decreased from 86% in 2014 to 81% for the trust, against the national average score of 86%.

Patients and relatives told us that staff were fantastic and that they felt cared for and safe at all times. However, they felt that they were not always involved in decisions, particularly around discharge arrangements.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust MUST take to improve

- The trust must ensure that the categorisation of incidents is completed accurately and full investigations are carried out as appropriate, including the identification of themes to ensure relevant actions are implemented.
- The trust must ensure that governance systems in place are effective. This includes ensuring practices are consistent, in line with hospital policies, and documents are approved through the clinical governance structure.
- The trust must ensure risk registers reflect the risks within the trust.
- The trust must ensure that staff receive appropriate training, in mandatory training, safeguarding, mental capacity and deprivation of liberty safeguards to ensure they have the most up-to-date knowledge and skills.
- The trust must ensure that staff have appropriate supervision and appraisals in relation to their role.

Action the trust SHOULD take to improve

- The trust should ensure that patients' pain is assessed as required and managed accordingly.
- The trust should ensure that all staff receive learning from incidents and complaints.
- The trust should ensure that all incidents are reported through their electronic reporting system as soon as is reasonably practicable.
- The trust should take appropriate action to ensure the appropriate skill mix is maintained to meet the needs of patients.
- The trust should ensure that they receive assurances around the competences for all staff that provide care and treatment and that they have the correct skills, specifically staff employed through a service level agreement.
- The trust should ensure patient records are transferred with the patient.
- The trust should ensure patients and their relatives, where appropriate, are involved in decisions relating to care, treatment and discharge planning.
- The trust should ensure patient records are accurate and complete, to include a record of their care and treatment, and treatment management plans are completed to reflect the identified risks.

Action the provider COULD take to improve

Wye Valley NHS Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

We found that:

Staff were knowledgeable about incident reporting and the new duty of candour regulation. However, we were not assured that all relevant investigations and risk factors were considered when reviewing incidents to ensure appropriate action was taken and lessons were learnt.

Records in relation to safeguarding were maintained appropriately and staff were aware of their responsibilities. However, safeguarding training data provided by the trust demonstrated that 52% of community inpatient staff had received appropriate training.

Systems, processes and standard operating procedures were not always reliable or appropriate to keep patients safe. Checks on fridge and room temperatures where medicines were stored varied and checks on medication that required stricter legal requirements were inconsistent.

Patient records were legible; however, nursing audits identified community inpatient staff did not always complete relevant assessments appropriately. There was no evidence as to what action had been taken as a result. Where risks had been identified through the form of an assessment, relevant management plans had not always been put into place.

The ward areas were visibly clean; however, cleaning audits identified that, at two of the community hospitals, estate areas were consistently below the expected cleanliness level.

The trust was actively trying to ensure there were sufficient numbers of staff in the community hospitals. However, we were not assured that appropriate action was taken to ensure an appropriate skill mix was maintained to meet the needs of patients and to keep them safe.

The risks associated with anticipated events and emergencies were not fully recognised, assessed or managed.

Safety performance

- Between May 2014 and April 2015, Wye Valley NHS Trust reported 13 serious incidents that required investigation within the community inpatient services. There were

seven at Bromyard Community Hospital, two at Hillside Intermediate Care Centre, one at Leominster Community Hospital and three at Ross Community Hospital. Six of these related to patient falls resulting in harm. We reviewed the investigations into the reports and found no emerging themes. However, the two community hospitals with the highest number of falls resulting in harm to the patient were Bromyard Community Hospital and Hillside Intermediate Care Centre where the layout of the ward at both hospitals meant each patient was cared for in a side room. None of the investigations we reviewed considered the environment and the risk this posed to patients who were assessed as having a high risk of falling. We could not be assured during the investigation; all risk factors were taken into consideration to prevent further harm.

- We reviewed an incident where a patient was given pain relief as needed (PRN) to assess how much they used before changing the route the medication would be administered. Nursing staff changed the route of pain relief to a syringe driver without calculating the amount of pain relief used and without a review by the doctor, as planned. This meant that the patient did not receive an adequate dose of pain relief. We saw that the patient was informed of the incident, and immediate actions were taken to resolve the error. This incident was not reported as a serious incident (SI) as it was felt by the trust that no harm had been caused. We were not confident that the possibility of psychological harm or ongoing physical harm to the patient from being under-prescribed pain relief was taken into consideration.
- Patient safety information was displayed on boards in all four community hospitals. This included the number of days the ward was free from a hospital-acquired pressure ulcer, number of days since the last fall that resulted in harm, and the number of days since the last **Methicillin-resistant Staphylococcus aureus** (MRSA) bacteraemia and Clostridium difficile (C. diff) infections. Information showed that Bromyard Community Hospital had three cases of C. diff between April 2015 and August 2015 and there was a further case at Leominster Community Hospital in April 2015.
- There were no 'Never Events' in outpatient services between May 2014 and April 2015 in the community hospitals. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.

Incident reporting, learning and improvement

- Staff informed us that they reported incidents using the trust's electronic incident reporting system, as well as alerting relevant senior staff members. Staff were aware that some incidents required a root cause analysis to be carried out and a debrief would be provided afterwards. For example, if there was an avoidable pressure ulcer (grade three or four), the tissue viability nurse and senior nurse were informed and an incident form was completed. Following this, a root cause analysis was completed and an action plan put in place. A pressure ulcer affects an area of skin and underlying tissue. A grade three or four pressure ulcer is more severe.
- Staff had an awareness of duty of candour and how this was relevant to their role. One staff member described potential incidents, for instance medication errors, and how the incident would be explained to the patient and any actions taken as a result.
- During our inspection, we noted that a patient had been transferred to an acute hospital. Before this, it was recorded that the patient had acquired a bruise on their leg overnight. We saw records to confirm appropriate actions that staff had taken, including taking photographs of the bruise with the patient's consent. However, an incident form had not been completed at the time. We brought this to the attention of staff who assured us that an incident form would be completed immediately. We did not seek assurances that the incident was reported.
- The head of nursing for community hospitals told us that they were automatically notified of any incidents that were rated as orange and red (an incident with an increased risk) by the electronic reporting system and their governance department. This was in line with the trust's incident management policy and highlighted any incidents with an increased risk.
- We were informed that lessons learnt from incidents was a standard agenda item discussed at ward meetings. However, minutes of ward meetings did not evidence this.

Safeguarding

- Staff at all four community hospitals were knowledgeable regarding safeguarding and the actions they would take if they had any concerns regarding a patient.

Requires improvement

Are services safe?

- At Ross Community Hospital, staff described in detail an example of a safeguarding concern, which had resulted in a Deprivation of Liberty Safeguards (DoLS). Records we reviewed demonstrated appropriate actions were taken by staff in accordance with the trusts' safeguarding process.
- We reviewed 16 medical records and noted that where appropriate, safeguarding referrals had been made by staff, in particular following witnessed incidents.
- Training data received from the trust indicated that as of May 2015, 52% of community inpatient staff had received safeguarding training. This was broken down to safeguarding adults level 1 (59%), safeguarding children level 1 (49%) and safeguarding children level 2 (43%). This was against a target of 90%. However, after the inspection the trust told us that there were updated figures available that showed increased levels of training but were unable to provide evidence to support this on our request. Staff were knowledgeable about safeguarding concerns, and it was evident the trust were improving their training attendance to ensure staff received training in the most current practice to safeguard and protect patients.

Medicines

- We observed medication rounds carried out by trained nurses. Patient name bands were checked and the patient was asked to confirm their date of birth. If a patient declined, this was recorded appropriately on the medication chart. This meant medication rounds were carried out safely.
- Fridge and room temperatures where medicines were stored were checked on a daily basis at all four community hospitals. Temperatures must be checked to ensure the efficacy of medicines is not adversely affected. We noted that at Leominster Community Hospital the fridge and room temperature was above the recommended limits for three consecutive months. An air conditioning unit had been fitted within the room and the temperatures had remained at a constant temperature within the expected range. However, staff were unable to tell us what actions were taken in relation to the medicines that were stored at an unacceptable temperature.
- At Ross Community Hospital, the room temperature was noted to be slightly higher than required (25.3 Celsius) and we raised this with the lead nurse. We also noted that the guidance regarding checking temperatures was not available in the clinical room as required. This was rectified once we had raised this. The fridge temperatures at Hillside Intermediate Care Centre noted two days in September 2015 where the temperature was below the storage temperature for insulin (1.3 Celsius and 1.6 Celsius). As a result, all insulins stored within the fridge were destroyed.
- The community hospitals did not have any non-medical or nurse prescribers. Nursing staff confirmed that GPs would write up patient medication. If medication was required out of hours, the out of hours GP service was contacted and would attend the relevant hospital. This was in line with the trust's medicines policy, which stated medical staff were responsible for the majority of prescribing of medicines for patients.
- During a patient's discharge, we observed that a verbal explanation was given to the patient on the medicines they required and the frequency of these. At Ross Community Hospital, we observed nursing staff requesting medication from Hereford Hospital for a patient who was due to be discharged that day. Nursing staff confirmed that the medication had been requested the previous day by fax and confirmed this with two telephone calls to Hereford Hospital. This was in line with the trust policy. However, the medication was not ready and the doctor on site completed a prescription for the patient to collect the medication from a local pharmacy. Staff explained that this was more costly to the hospital, however ensured that the patient received their medication.
- We reviewed 16 patient records and prescription charts and noted that the patients name and NHS number was noted on the front page only and not each page as required. This meant that relevant paperwork was not always completed accurately.
- Controlled drugs (CDs) (a medication listed in schedules one to five of the Misuse of Drugs Regulations 2001 that require stricter legal controls to prevent misuse and harm) were checked on a daily basis. At Ross Community Hospital, we noted that the daily checks were carried out by one nurse rather than two. At Leominster Community Hospital, an audit had been carried out by a pharmacist and a nurse; this had highlighted that during September 2015 one nurse had checked the CDs on a daily basis rather than two. This meant that the practices carried out at the community hospitals were inconsistent and not always in line with trust policy.

Requires improvement

Are services safe?

Environment and equipment

- Audits were carried out on the daily checks of resuscitation trolleys. The results from the last audit in May and June 2015 showed that three community hospitals with the exception of Ross Community Hospital had achieved 100% compliance matched against a trust target of 90%. We reviewed the resuscitation trolleys and noted that daily checks were completed, emergency medicine was in date and the trolleys were cleaned weekly. At Bromyard Community Hospital, we raised to the ward manager that the bag for one airways device had split open. This meant that the device was no longer sterile and this was replaced immediately.
- A memo had been sent to all four community hospitals in September 2015 to inform staff that injectable medicine ampoules should be stored in their original boxes in resuscitation trolleys. However, we noted that this had not yet been adhered to at Leominster Community Hospital and Bromyard Community Hospital.
- We checked equipment to ensure that it had been serviced, maintained and tested (portable appliance testing, PAT) as appropriate. We saw that equipment had been serviced, maintained and PAT tested to ensure it was safe and fit for use. Therapy staff confirmed that a record of equipment purchases was kept and visual checks were carried out. However, the responsibility for the maintenance was held by an external provider.
- We saw that there had been a leak in the ceiling of the dining room at Bromyard Community Hospital. The light near the leak had been removed for safety reasons. The ward sister informed us that this had been raised with maintenance; however, no date had been set to resolve the problem. This meant that staff had to ensure patients did not go near this area during bad weather to prevent harm
- Minutes from ward meetings at Leominster Community Hospital detailed staff discussions regarding the appropriateness of some equipment and whether it was fit for purpose. This included, new reclining chairs, weighing scales and commodes. It was noted that the new reclining chairs were currently not used, as they had no wheels or brakes and took two staff members to glide the chair across the floor. The minutes stated that the weighing scales and commodes were not fit for purpose. The weighing scales were difficult to use and the footplates were not practical. Commodes were too flimsy and not substantial for use. Staff requested to be involved in future trials; however, the minutes from the meeting did not identify any other action to be taken. This meant that we could not be assured that staff were involved, as required, regarding appropriate equipment purchases to ensure they were fit for use and the safety of patients and staff was not put at risk.

Quality of records

- We reviewed 16 patient records across the four community hospitals and noted that all were legible, complete and accurate. This meant patient records were maintained appropriately to ensure patients received safe care and treatment.
- The one exception we noted related to an illegible signature by an admitting doctor at Bromyard Community Hospital. The signature was not on the personal list in the patients' records and when we asked staff, they were unable to recognise who the doctor was.
- On the evening of the 22 September 2015 whilst inspecting Hillside Intermediate Care Centre, we noted that the door to the clinic room was open. There were two doctors communication books, which contained patient identifiable data, left on the side. There were also two drawers, which were not locked, which contained patient identifiable data. This meant there was a risk that patient information could be obtained by other patients or visitors to the hospital.
- Nursing records were audited on a spot check basis and looked at five sets of patient records. Specifically, patient observations, falls assessments, tissue viability assessments, nutritional assessments and missed dose and allergy status for completeness. We reviewed the results from July 2015 to September 2015, however none were provided for Ross Community Hospital. We noted that completeness of nutrition assessments was not to the same level as patient observations, falls and tissue viability assessments. The average for completion of nutrition assessments across the three sites was 77.5% compliant for this period. We were not provided with any action plans as a result of the findings.

Cleanliness, infection control and hygiene

- All ward areas looked visibly clean and hand washing gel dispensers were available on entry to all ward areas.
- Staff were observed and noted to be 'bare below the elbow' in line with the trusts' infection prevention and

control policy. During a medication round, we observed a staff nurse cleaning their hands between each patient. This meant staff adhered to trust infection prevention and control policies, as well as Department of Health best practice guidance 2008.

- We observed staff at the four community hospitals wearing appropriate personal protective equipment (PPE). For instance, gloves and aprons when required, including when disposing of waste. However, we also observed one instance, at Ross Community Hospital, when soiled linen sheets were bagged in the corridor by the nurses' station.
- Chairs, equipment and trolleys had green 'I am clean' stickers on them with the date and time they were last cleaned. This meant that patients could be assured that all equipment, medical and non-medical, had been cleaned to reduce the risk of infection.
- We found that there were sharps disposal bins located, as appropriate; to ensure the safe disposal of sharps, for example needles. Labels were also completed to inform staff when the sharps disposal bin had been opened.
- Before our visit, we reviewed infection prevention and control audits for the community hospitals, which identified poor maintenance of the general environment. For example damaged door frames, floor seals and skirting. Although the audits and subsequent action plans did not identify evidence of action taken, we observed that action had been taken to address the maintenance of the environment and mitigate any potential risk to patients.
- Infection prevention and control audits were undertaken for hand hygiene and the cleanliness of commodes. We also noted that the trust participated in the high impact intervention audits (a Department of Health initiative to ensure appropriate and high quality patient care) and each community hospital displayed the results within the ward area. We noted that as of August 2015, each community hospital had achieved 100% for hand hygiene and high impact interventions where applicable, for example, insertion and ongoing care of a urinary catheter.
- With the exception of Leominster Community Hospital in August 2015 for commode cleanliness, all community hospitals achieved all decontamination audits. Decontamination audits included commode cleanliness, commode documentation and toileting aids.
- The trust carried out monthly credits for cleaning (C4C) audits, which measured and monitored the cleaning standards in three sections; estates, nursing and cleaning. The trust target for each of the three sections was 90%. We noted that from April 2015 to August 2015, the four hospitals achieved the target for cleaning and nursing. However, the estates section, did not always achieve the target. This was particularly relevant to Leominster Community Hospital and Ross Community Hospital, where the average score was 51% and 37% respectively.

Mandatory training

- The trust submitted mandatory training data as of May 2015 before our visit. This highlighted that mandatory training for community inpatient staff was below the trusts' 90% target; however, the data was not split down to individual community hospitals. Overall compliance included infection control (59%), dementia (62%), moving and handling (57%), equality and diversity (69%) and information governance (45%). This meant we could not be assured there were consistent systems in place to enable staff to receive appropriate training and to ensure patients received safe care and treatment.
- Therapy staff informed us that they had been trained in moving and handling and additional training was available with the manual handling assessor from the relevant equipment companies. This meant therapy staff received appropriate training to reduce the risk of injury to themselves and patients during the provision of care and treatment.
- Staff informed us that with the exception of e-learning, mandatory training was carried out at Hereford Hospital. Senior nursing staff explained that they wanted to look at how mandatory training was delivered within the community hospitals to prevent staff having to attend the acute site, and reduce the amount of time staff were away from patient care.
- During our visit, nursing staff and healthcare assistants informed us that their mandatory training had been completed over the last two weeks.

Assessing and responding to patient risk

- We reviewed 10 patient notes across the four community hospital sites and looked specifically at the completion of Waterlow assessments, (a Waterlow assessment is a risk assessment tool to measure the risk for a patient that may acquire a pressure ulcer). We

noted that six of the tools were not completed appropriately. For example, for one patient at Leominster Community Hospital, the Waterlow score had increased from 8 to 13, however, there was no documentation in the nursing records as to what actions had been taken as a result. We raised this with a qualified nurse who informed us that they would review the patient records. At Ross Community Hospital, we noted four out of eight assessments had relevant actions identified, however these had not always been carried out. This included, ensuring the patient had an appropriate mattress. At Hillside Intermediate Care Centre, a Waterlow score had been recorded for one patient, however the chart was not completed to evidence how the score had been calculated. We raised this with nursing staff and were told that the chart was completed in the nurses' head.

- The community hospitals used the national early warning score (NEWS) in line with Hereford Hospital. Within the patient records we reviewed, we noted that NEWS was completed appropriately as required. A NEWS audit was carried out in March 2014 and October 2014, however the audit did not differentiate between acute and community inpatients. As a result of this audit, a revised NEWS chart was to be launched in October 2015 with the intention of improving the recording of the Situation, Background, Assessment and Response (SBAR). SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety.
- The ward meeting minutes from Leominster Community Hospital in April 2015 demonstrated discussion of an incident where a patient had two falls during their stay. On review of the incident, it was noted that the falls risk assessment had been completed appropriately, identifying that the patient was high risk, however a management plan had not been put into place. On review of the patient records at the four community hospitals, we noted that only one falls risk assessment had not been completed correctly and actioned.
- We observed a handover at Bromyard Community Hospital, which included staff nurses, physiotherapy staff and an occupational therapist assistant. All 14 inpatients were discussed including risks, actions required and potential discharges. A GP confirmed that a doctor's book was used at the community hospitals for handover and escalation, and a verbal handover was provided at the GP practice for any cover arrangements.
- Staff at all four community hospitals explained that if a patients' health deteriorated they would liaise with the appropriate doctor, GP or out-of-hours service first, depending on the situation. If the patients' condition required more urgent attention, ward staff would dial 999 for readmission to Hereford Hospital.
- This meant that relevant overall risk assessments were not always completed appropriately, and where risk had been identified, not all actions were put into place. A process was in place to discuss individual patient risk at handovers between the relevant health professionals, verbally and by use of a communication book. However, patient records were not maintained appropriately and actions taken to mitigate the risks identified and preventing potential harm to the patient.

Staffing levels and caseload

- Ward staff informed us that staffing levels and vacancies were their biggest worry. At Bromyard Community Hospital, nursing staff and healthcare assistants had increased their hours, where possible, on a three-month basis to alleviate staffing pressures and reduce the risk of unsafe care to patients.
- The head of nursing for community inpatients provided data as of 22 September 2015 to show that the vacancy rates for all staff groups were; 1.2 whole time equivalent (WTE) at Ross Community Hospital, 2.9 WTE at Leominster Community Hospital, 0.07 WTE at Bromyard Community Hospital and that one staff nurse vacancy at Hillside Intermediate Care Centre was about to be filled. However, two staff working additional hours at Bromyard Community Hospital were reducing their hours at the end of November 2015 and it had been confirmed that an agency nurse had accepted a permanent contract. However, there was no additional information about the forthcoming vacancies at Bromyard Community Hospital after November 2015.
- Ward staff at Bromyard Community Hospital informed us that the ward manager regularly worked clinically. The ward manager confirmed that they generally worked four days clinical and one day supernumerary to complete their managerial role, however due to time constraints found it difficult to complete all managerial tasks.

Requires improvement

Are services safe?

- The trust provided data regarding the percentage of bank staff used at the community hospitals as of May 2015. Bromyard Community Hospital had an average of 25.3%, Ross Community Hospital had an average of 12.2%, Leominster Community Hospital had an average of 13.5% and Hillside Intermediate Care Centre had an average of 9.2%. This was against a trust average of 13.5%.
- Ward staff explained that bank staff and agency staff were used to address any gaps. When agency use was required on a frequent basis, the community hospitals requested the same staff member to reduce any potential inconsistencies in patient care. At Bromyard Community Hospital, block bookings of agency staff were confirmed to meet winter pressures and the bed numbers were increased. Staff confirmed that bank and agency staff received a local induction, including orientation to the ward and what to do if a patients' health deteriorated. We saw records to confirm local inductions were carried out.
- All four community hospitals displayed information regarding the agreed and actual staffing levels for each shift (early, later and night) in relation to qualified staff and healthcare assistants. At Hillside Intermediate Care Centre, additional healthcare assistants were on shift during our visit as four patients required one-to-one support. We were informed that the community hospitals worked together in the first instance for staff cover and it had been agreed, based on patient needs, that one healthcare assistant from Bromyard Community Hospital would assist at Hillside Intermediate Care Centre at night, leaving them one staff member short. However, this information was not reflected on the information displayed.
- Ward staff at Ross Community Hospital informed us that if patients required one to one support, this was difficult to cover due to staffing levels. The ward manager confirmed that they had received patients with more complex problems due to the restrictions on the type of patient Bromyard Community Hospital could admit. This then affected the number of falls, management of patients living with dementia and safe care at Ross Community Hospital. We were informed that a staffing review was completed every six months and the staffing establishment had remained unchanged. There was one trained nurse to 14 patients, one trained nurse to 18 patients and an additional trained nurse to assist with all 32 patients at Ross Community Hospital. The ward manager explained that to meet the acuity needs of the patients an additional trained nurse was required.
- The head of nursing for community hospitals confirmed that the safer staffing assessment tool was used to plan staffing levels with professional judgement and felt that the right skills were in the right place. We reviewed the staffing levels for the three months before our visit and noted that newly qualified nurses were identified on the rota in line with the trusts' policy. However, agreed staffing levels were not always met. For example, at Hillside Intermediate Care Centre, agreed staffing levels included three trained nurses on an early and late shift and two on a night shift, as well as four healthcare assistants on an early shift and three on a late and night shift. However, staffing rotas confirmed that on an early shift there were often two trained nurses and five healthcare assistants.
- The trust were actively trying to ensure there were sufficient numbers of staff deployed in the community hospitals, however we could not be assured that appropriate action was being taken to ensure the appropriate skill mix was maintained to meet the needs of patients.
- Physiotherapy staff based at the community hospitals confirmed that they were included in the on call rota, which covered Hereford Hospital. Staff informed us that recruitment was a problem at times and that five vacancies had recently been recruited to at the acute site, but none to the community hospitals. At Hillside Intermediate Care Centre, the physiotherapist was a lone worker and cover was not organised for single days off. This meant that the community hospitals did not always have adequate physiotherapy staff to assist with patients' rehabilitation.
- The medical cover for each of the four community hospitals varied and included support from primary care. At Ross Community Hospital, a full time Senior House Officer (SHO) provided cover, with support from a local GP practice. The SHO was on site Monday to Friday. A GP was based at Leominster Community Hospital site five hours a day, Monday to Friday. The out-of-hours service was provided by GPs employed by primary care services provider Primecare under a service level

agreement. Medical cover at Hillside Intermediate Care Centre was also provided by Primecare and the patients at Bromyard Community Hospital were managed by a local GP practice.

- The head of nursing for community inpatients explained that the trust was currently in the process of developing an escalation process if there was no GP cover, for example, due to sickness. However, they confirmed that Primecare would be contacted for cover.
- Senior management informed us that the trust was trying to standardise the medical cover provided at the community hospitals, however this was challenging due to their inability to recruit community geriatricians.

Managing anticipated risks

- Bromyard Community Hospital admitted a maximum of 14 patients at a time; however had the ability to increase this amount to 24. Nursing staff confirmed that patient numbers in the hospital could be increased over a weekend and additional nursing staff would be requested. However, physiotherapy support and social work support was not in place and there was no notice given to the GP. This meant that although the hospital had the ability to manage anticipated risks, for example, an increase in patient numbers, appropriate staffing levels and systems to alert relevant health professionals were not in place.
- Ward staff told us that as part of the trusts' winter pressures plan, Bromyard Community Hospital would increase their bed numbers to 24.

Major incident awareness and training

- Ward staff at all four community hospitals confirmed that a major incident plan was in place; however felt that it needed to be reviewed to ensure it reflected the role of community hospitals. Staff explained that their role in a major incident was to be 'back up' for the acute site.
- The trusts major incident plan had a date for review of October 2014. It was noted within the plan that community hospitals would support Hereford Hospital in accelerating existing patients through the system in the event of a major incident to enhance existing bed space, as well as the redeployment of staff. This meant that staff were working to a plan that was past its review date and had implications that the appropriate process to be followed would not be adhered to.

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.

We found that:

Care and treatment did not always reflect current evidence-based guidance, standards and best practice. This included National Institute for Health and Care Excellence (NICE) guidelines. Care assessments did not consider the full range of patients' needs, in particular pain management.

There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development.

There were inconsistencies in staff maintaining competencies and developing their roles through additional training. There was no assurance regarding the revalidation and appraisal for the GPs providing medical cover at the community hospitals.

Relevant staff were included in the assessment, planning and delivering of patient care and treatment and GPs were able to access patient results from the trust's electronic reporting system. This meant that there were no delays in GPs accessing necessary and relevant patient information while delivering care and treatment.

Staff had a good awareness of the Mental Capacity Act 2005 (MCA) assessments and Deprivation of Liberty Safeguards (DoLs). However, completed records were inconsistent in relation to when a mental capacity assessment was completed.

Evidence based care and treatment

- Physiotherapy staff at Leominster Community Hospital confirmed that a care pathway was in place for patients who had a fractured neck of femur and that it was not followed rigidly. We reviewed 16 patient records, eight of which were specific to patients who had a fractured neck of femur. We were unable to see a pathway in place or checklist for care.
- Seven of the eight records indicated, in line with National Institute for Health and Care Excellence (NICE), that the patient should be prescribed calcium and vitamin D. In one of the patients' records, it had been documented that calcium and vitamin D should be considered, however this had not been prescribed and there was no written explanation as to why it was not prescribed. This meant that we were not assured that best practice guidance was considered.
- Ward staff informed us that when a patient was transferred from Hereford Hospital, nursing staff would speak to the relevant ward area regarding the patients' skin assessment. A patient's Waterlow score was then carried out in the first six hours of their admission, a skin check was carried out and SSKIN care bundles put into place as required (SSKIN is a five step model for pressure ulcer prevention). We reviewed eight patient records at Ross Community Hospital specifically looking at the SSKIN care bundles and found that two were fully completed. This meant we were not assured that risk was being identified and the appropriate pathway adhered to.
- The head of nursing for community hospitals confirmed that compliance with best practice was not audited. However, localised nurse led audits were carried out, for instance SSKIN care bundles. This involved a spot audit of five patients per week. The results and information obtained from the audits was not utilised on a wider level to ensure ongoing compliance was monitored and lessons were learnt.
- GPs confirmed that they had access to relevant guidelines, including national and local guidelines which were available on the hospital intranet. They were able to demonstrate how they accessed these guidelines.

Pain relief

- Nursing staff confirmed that pain assessment charts were in place.
- We reviewed records for two patients where it had been indicated a pain assessment chart was in use. At Hillside Intermediate Care Centre, the pain chart had been completed over the two days following the patients' admission. At Ross Community Hospital another patients record's identified that the patient was in pain on 10 August 2015 and had a weekly painkiller patch. However, a pain assessment chart had not been completed and there were no other management plans

in place in relation to pain. This meant that although it had been identified that the patient was in pain, ongoing assessment and management of the pain was not documented or monitored.

- At Hillside Intermediate Care Centre, we requested to see a copy of the pain chart used. We were provided with a pain chart which had been developed by another trust which had copyrights of the document. The ward manager confirmed that there was not a policy or standard operating procedure for the use of the document. We were informed that the document had not been approved by the trust clinical governance process.

Nutrition and hydration

- At Ross Community Hospital we reviewed eight patient records in relation to the completion of the Malnutrition Universal Screening Tool (MUST) and noted that all assessments had been completed accurately. This meant staff were able to identify patients at risk of malnutrition and took appropriate actions to mitigate this risk.
- Ward staff confirmed that nutritional supplements could be prescribed if they had been identified for a particular patient.
- Diet and texture information was displayed in the dining rooms at Hillside Intermediate Care Centre, which provided a description and examples related to each national code and menu code. Pictures of the various fluid containers used were also displayed with the amount of fluid each contained. This helped staff to recognise at a quick glance how much fluid a patient drank and what their dietary requirements were, as indicated in their records.
- Ward meeting notes from Bromyard Community Hospital encouraged staff to escalate to a GP if it was felt that a patient was not drinking enough fluids. Staff were also reminded to complete fluid balance charts if a patient refused a drink.

Patient outcomes

- The trust collated monthly data in relation to patients living with dementia. This was in line with a national Commissioning for Quality and Innovation (CQUIN) indicator to find, assess, investigate and refer relevant patients. We noted that as of July 2015, the trust was achieving all the targets.
- We noted that the trust carried out an audit in relation to diagnosis of urinary tract infection (UTI) in older people. We were informed that the local audit carried out did not include data from the community hospitals as those patients who were more unwell would be transferred back to Hereford Hospital for treatment.
- Ward staff informed us that expected discharge dates (EDD) were set. However this information was not always given to patients until nearer to the expected discharge date, if there was a long duration of time until discharge. At Leominster Community Hospital, ward staff informed us that multidisciplinary teams set the EDD and we saw in all four community hospitals EDDs noted on the ward information boards for each patient. However, the head of nursing for community inpatients informed us that the EDD in community hospitals was not monitored as a measurement of patient outcomes.
- Senior management informed us that cases where patients were readmitted to Hereford Hospital from a community hospital were investigated. This was completed using a checklist exercise. Avoidable admissions were monitored which included reviewing all patients where their length of stay was less than 24 hours.
- We were also informed by the head of nursing for community hospitals that nursing safety indicators were used; however additional work was required with the ward sisters on utilising the data. The nursing safety indicators looked at the completeness of records for patient observations, falls, tissue viability and nutrition assessments.
- Physiotherapy staff informed us that they used the De Morton Mobility Index (DEMMI) to assess a patients' basic ability. The assessment included goals which were agreed in consultation with the patient. However, physiotherapy staff at Ross Community Hospital informed us that this information was used as evidence and the assessments and goals were not audited to review patient outcomes. Physiotherapy staff at Hillside Intermediate Care Centre informed us that the use of DEMMI would commence on 28 September 2015. This meant there was no consistency in use of the tool or measurement to ensure the tool was effective and helped to improve a patients' outcome.

Competent staff

- The appraisal rates as of May 2015 for the Urgent Care and Care Closer to Home service were 63% for nursing

and midwifery registered staff, 61% for additional clinical services staff and 54% for allied health professionals. However, after the inspection the trust told us that there were updated figures available that showed increased levels of training but were unable to provide evidence to support this on our request. At Bromyard Community Hospital, the ward manager informed us that their appraisal rates were around 90%; however this information had not been updated onto the electronic staff record (ESR). This meant that we could not be assured that all staff received appropriate support through the appraisal system.

- Staff informed us that they were encouraged to attend clinical supervision training and that at the time of the visit; clinical supervision was not formally carried out. Ward managers informed us that they would use the time after handover for clinical supervision with staff members and received peer support through a sister's meeting. This meant that there was no embedded system to ensure all nursing staff were able to access appropriate clinical supervision and maintain and promote standards of care.
- The trust's ESR system flagged to relevant staff when a staff member's professional identification number (PIN) was due for renewal and provided two months' notice. This meant there was a system in place to ensure nursing staff maintained their professional registration.
- Nursing staff were also informative on the forthcoming revalidation requirements. The Assistant Director of Nursing led a revalidation group and a list had been collated of all staff and when they were required to revalidate. Workshops were being introduced to help staff complete their portfolios.
- Staff competencies were assessed at Hereford Hospital. At Leominster Community Hospital, staff informed us that their competencies for intravenous (IV) antibiotics and blood transfusion were maintained regularly so that patients requiring IV antibiotics or a blood transfusion did not require an acute hospital admission.
- At Bromyard Community Hospital, nursing staff informed us that their competencies were not always maintained due to the acuity of the patients admitted. This meant that acquired skills were not frequently used. However, we were informed that practitioners from Hereford Hospital would provide support and training if this was required.
- Therapy staff and nursing staff informed us that they had been encouraged to attend a leadership course. One senior nurse told us that this had been identified through their appraisal process and found the course to be very good. A physiotherapist informed us that they had to be self-directed in seeking out courses, however their manager would approve additional courses if they felt it was required. This meant that there were inconsistencies in staff maintaining competencies and developing their roles through additional training.
- GPs at Bromyard Community Hospital and Leominster Community Hospital informed us that they had received their appraisals and that their appraiser was allocated through the relevant clinical commissioning group (CCG). They informed us that they maintained continuous professional development specific to their role at the community hospitals.
- A consultant informed us that medical consultants had raised concerns in the past regarding risks in the community services. Concerns related to the fact that although the GPs had good skills, they were not geriatricians.
- A senior house officer (SHO) was in post at Ross Community Hospital. We were informed that this post was not a training post and the geriatricians based at Hereford Hospital were not involved in the appointment of the SHO.
- Senior management confirmed that with exception of the SHO, who was employed by the trust, there was no assurance regarding the revalidation and appraisal for the GPs providing medical cover at the community hospitals. A service level agreement (SLA) was in place, however this assurance did not form part of the agreement and the trust were looking into how this assurance could be sought.

Multi-disciplinary working and coordinated care pathways

- All staff we spoke with were aware of who had overall responsibility for the patients at each of the four community hospitals. The head of nursing for community hospitals confirmed that when patients were transferred from the acute site to a community hospital they no longer remained under the care of the consultant at Hereford Hospital but followed one single pathway for treatment.
- Nurses and healthcare assistants told us that there was no geriatrician support unless advice was specifically sought. However, multidisciplinary team (MDT) meetings were held on a Monday with health

professionals at each of the community hospitals. Daily handovers also took place and the ward clerk printed a list of the inpatients for discussion at the handovers. Staff informed us that MDT working and daily handovers aided joint working. We reviewed 16 patient records at the community hospitals and noted that multi professional meetings were held to discuss plans and future care needs of the patient.

- A huddle was held every Tuesday and Friday, which meant a staff member from each community hospital, joined a meeting at Hereford Hospital through a telecom. This involved a physiotherapist, the ward sister, an occupational therapist, a neighbourhood team occupational therapist and the discharge liason team based at Hereford Hospital. One staff member at Ross Community Hospital informed us that the huddles were time consuming and added no real benefit. They felt that the meeting was used to see what beds would be available rather than overall planning or a way of following up actions.
- Information from social workers was received before the huddle; staff confirmed that the community hospitals no longer had an allocated social worker, however found them to be approachable on the telephone. Information from the huddle would then be added to the handover. This meant that relevant staff were included in the assessment, planning and delivering of patient care and treatment.

Referral, transfer, discharge and transition

- GPs informed us that unsuitable and unsafe transfers still occurred.
- Staff informed us that transfers from Hereford Hospital could occur late at night, for example 10.30pm. Data from July 2015 to September 2015 showed that a total of 192 patients were transferred from Hereford Hospital to a community hospital between the hours of 6pm and 5am. The trust's transfer policy, which had a review date of February 2015, contained a protocol in relation to transfers to the community hospitals. This protocol stated that 'transport arrangements should be appropriate to the patient's needs and agreed, and where possible occur during daytime hours. There was no further guidance regarding transfer times from Hereford Hospital to a community hospital.
- A standard form was in use for handover which included the patient's plan of care.
- There were no monitoring systems in place for discharges; however staff informed us that they aimed to discharge a patient after they had received a meal. At Leominster Community Hospital, nursing staff told us that the patients' family would be involved in a discussion regarding discharge time and if the patient was being discharged to a nursing home, the nursing home would not accept the person after a certain time. The latest discharge time would be 6pm
- At Ross Community Hospital, ward staff felt that weaknesses in the discharge process related to mental health assessment and support and transfer to social care. Referrals to the duty social worker were paper based and staff felt that if they had the ability to do the referral electronically, this would speed up the process.
- Senior management informed us that the community hospitals had a low delayed transfer of care rate and that social care colleagues worked on site which assisted with this. As of the 09 July 2015, there had been seven delayed transfers of care. Staff also informed us of a number of beds which were based in nursing homes, which they referred to as RAAC beds. Senior management confirmed that this was a scheme called Rapid Access to Assessment and Care. There were 10 beds in two nursing homes which could facilitate patients who were intended to have a maximum length of stay of no more than two weeks. This enabled discharge for patients who were medically fit and only required social care packages to be in place.
- Therapy staff confirmed that a summary was completed for each patient after they had been discharged. A specific therapy handover was not given to GPs on discharge; this was incorporated into the nursing information. If a patient required additional support once they had been discharged, the therapy staff liaised with the neighbourhood teams to ensure the patient received continued support as required.

Access to information

- During our inspection, the information technology system, specifically the shared drive, was not working. This meant that staff were unable to print off diary and handover sheets. We saw that there were actions in place to ensure handovers could continue using a paper–based format. Staff confirmed that they were still able to access patient results.
- Ward staff informed us that at times, patients were transferred from Hereford Hospital without the relevant

information or patient records. In the event of this happening, the transferring ward would be notified straight away and the patient's records would be sent in a taxi to the community hospital. An incident form would be completed. We reviewed one incident where a patient was transferred with no medical records. When the patient was found unresponsive, staff carried out cardio-pulmonary resuscitation (CPR) without knowing if this was in line with the patients' wishes. As a result of the incident, emergency department staff were reminded of their responsibilities to ensure medical records are transferred with patients to a community hospital.

- Medical staff informed us that the patient administration system was 95% accurate and sometimes could not identify the patient's location. This was in the event of a patient being moved from one ward to another, or from Hereford Hospital to a community hospital.
- GPs confirmed that they were able to access patient results from the trusts' electronic reporting system. This meant that there were no delays in GPs accessing necessary and relevant patient information whilst delivering care and treatment.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Nursing staff had a good awareness of Deprivation of Liberty Safeguards (DoLS) and informed us that all staff, with the exception of newly recruited staff had received training.
- We reviewed one set of patient records where a DoLS had been put into place and noted that all appropriate actions and discussions had taken place. This included best interest decision making and reviewing a DoLS application after an agreed timescale.
- Some ward staff told us that they experienced communication difficulties with DoLS assessors. However, if a social worker was on site, they were asked to be part of the discussions to minimise any difficulties.
- We reviewed one patient record that stated the patient had no capacity. Although a mental capacity assessment had been completed for one aspect of the patients' treatment, a mental capacity assessment had not been carried out for another, which was required. It was documented in the records that discussions had taken place with the patients' relative; however an appropriate assessment had not been completed.
- Staff were knowledgeable about the Mental Capacity Act 2005 (MCA) and informed us that they had received training; however training records demonstrated that 33% of community hospitals staff had received DoLS training and 46% had received MCA training. We were not assured that consistent practices were carried out in relation to assessments.
- Therapy staff informed us that consent was monitored by their line manager. They explained the process of taking a patients consent for plans of rehabilitation and that this would also be communicated to the patients' relatives, with permission.

Good

Are services caring?

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

We found that:

Patients and relatives were positive about the way staff treated them. Patients were treated with dignity, respect and kindness.

Patients and relatives informed us staff did not always involve them in their care or that of their loved one, particularly discharge planning.

Staff helped patients and those close to them to cope emotionally with their care and treatment.

Patients were supported and encouraged to manage their own health and care when they could, to maintain their independence.

Compassionate care

- The 2015 Patient-Led Assessment of the Care Environment (PLACE) score for privacy, dignity and wellbeing had decreased from 86% in 2014 to 81% for the trust, this was against the national score of 86%.
- Patients and relatives told us that staff were fantastic and that they felt cared for and safe at all times. One relative told us that staff were friendly and one patient told us that is was "like being with your family".
- We observed staff supporting patients to move from one area of the ward to another, whilst maintain the patients' dignity. For example, assisting a patient who was visually impaired to make their own way from one area of the ward to another. During this time, the staff member remained polite explaining what they needed to do and giving appropriate advice.
- We also observed nursing staff and healthcare assistants knocking on doors to side rooms before entry, and knocking on the door of a toilet before entering to ensure the patients' privacy and dignity was maintained.
- We observed several examples of staff being kind and respectful to patients and reassuring relatives over any concerns or anxieties that they may have had. However, there was one incident when a healthcare assistant was heard to be telling a patient loudly that they needed to be 'cut in half' and that they needed more staff.
- A senior nurse at Ross Community Hospital explained how the hospital had helped a young patient. The patient was on the ward for a long period of time and during the rehabilitation process was nursed back to full health. As a result of this, the patient had sent a thank you card to the staff.

Understanding and involvement of patients and those close to them

- Patients and relatives told us that the main aspect of not being kept informed was regarding discharge planning arrangements. One patient at Hillside Intermediate Care Centre told us that their discharge planning arrangements had been changed several times in one day, which they had found upsetting.
- Ward information displayed at Bromyard Community Hospital and Leominster Community Hospital stated that staff were not always forthcoming with information and patients did not feel involved in their discharge planning. Actions to mitigate this included maintaining communication with patients and the design of 'my discharge journey' document. This document was still under discussion at the time of our inspection.
- One patient and their relative told us that they had not been involved in their discharge planning, however we noted that on the board staff used, that there was a date provided for their expected discharge.
- Staff informed us that patients did not always want to engage in the plans regarding discharge.
- Although actions were being taken to improve the involvement of patients and their relatives, we were not assured that patients were consistently being involved, specifically around discharge arrangements.

Emotional support

- One patient explained that they had been in the hospital for many weeks and due to the encouragement provided by staff, they had much more confidence in themselves and their own wellbeing.
- We observed examples of nursing staff, healthcare assistants and therapy staff encouraging patients to manage their own health, including in participating in exercises to improve their mobility.
- Ward staff informed us that members of the church visited the community hospitals and visited any patient

Good

Are services caring?

that requested to speak with them. This was not specific to church members and provided an independent service to patients to talk about their health and wellbeing, if a patient chose to do so.

Requires improvement

Are services responsive to people's needs?

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

We found that:

When planning services, the needs of the local population were not always fully understood or taken into account.

Staff were aware of specific needs individual patients had and were able to implement appropriate arrangements, where possible.

Access to the therapy services was not always available in line with the patients' individual needs.

Staff were knowledgeable about the complaints process and what action they would take, although records demonstrated that there was limited learning across the sites from complaints and concerns.

Planning and delivering services which meet people's needs

- A System Resilience Group (SRG) met weekly, which included the local ambulance provider, independent health provider and mental health provider. Performance, wait times, ambulance wait times, delays in mental health assessments, patient flow, delayed transfers of care rates, discharges, and support for patients were discussed. Senior management from the service unit attended these meetings and reported any exceptions, which included from the community hospitals. The head of nursing for community hospitals was aware of discussions that took place with stakeholders and commissioners but was not involved in them.
- Senior management from the service unit and ward staff at Bromyard Community Hospital informed us about a workshop that had taken place with commissioners. The purpose of the workshop was to discuss the services currently provided and how services could be developed to meet the needs of the local population. At the time of our visit, the outcome of the workshop and planned actions were in discussion.
- The head of nursing for community hospitals and nursing staff at the community hospitals informed us that the trust had admissions criteria for the community hospitals and confirmed that this was generic and not specific to each community hospital site. However, when we asked to see a copy of the criteria, we were informed that there was not a written criterion for admission for the community sites and that a policy was planned. The process was for all community hospitals to accept patients who no longer required acute medical intervention but needed rehabilitation or complex discharge planning with the support of the multi-disciplinary team. In addition, direct admissions were accepted which included palliative care patients. All referrals were reviewed by the nurse in charge before accepting the patient to ensure the admission was appropriate.
- Due to staffing concerns, two standard operating procedures (SOP) had been implemented at Bromyard Community Hospital. The SOPs had been put into place to ensure patients with high dependency needs were not admitted to the hospital. At the time of our visit, the ward sister confirmed that they continued to admit patients outside of the SOPs including those patients living with dementia dependant on the stage of their disease.
- Admissions to the four community hospitals were predominately from Hereford Hospital and for the purpose of rehabilitation. A small percentage of patients were admitted directly from their GP. Ward staff and senior management confirmed that patients would be transferred to a community hospital closest to their home address, if this was possible. For example, nursing staff at Bromyard Community Hospital confirmed that when out of area patients were admitted they would be transferred to a community hospital closest to their home address, once a bed was available. This meant that the trust, where possible, planned inpatient care in response to their individual needs.
- Ward staff at Leominster Community Hospital informed us that patients with high medical needs would be transferred back to the originating hospital, for example Hereford Hospital. Incident data from April 2015 showed that three patients had been transferred from a community hospital back to Hereford Hospital.
- The head of nursing for community hospitals told us that a GP practice was linked to each community hospital. If a GP wanted to admit a patient, they would contact the relevant sister in charge to see if a bed was available. The community hospitals worked with the

complex discharge team based at the acute site to check the daily bed status. This allowed the trust to plan potential transfers of patients to a community hospital closer to their home, if appropriate.

- The ward sister at Hillside Intermediate Care Centre informed us that they challenged potential admissions where the patient could be discharged home with support from the neighbourhood teams, in particular the virtual wards. They confirmed that there were times when patients were admitted that could have been discharged home if social care packages had been in place. We reviewed data that demonstrated the percentage of patients discharged within 48 hours of admittance to Hillside Intermediate Care Centre. 42 patients were discharged in August 2015, 5% of which were discharged within 48 hours. Between April 2015 and August 2015, the percentage of patients discharged within 48 hours following admittance ranged between 4% and 7%. At the time of our inspection, two patients had been waiting for a package of care for the previous two weeks. This demonstrated the number of patients transferred from Hereford Hospital to Hillside Intermediate Care Centre that required social care packages to be in place before discharge.
- Senior management confirmed that an arrangement was in place with two nursing homes to utilise 10 beds for rapid access to assessment and care (RAAC). Therapy staff informed us that these patients continued to be seen by them if required, however due to capacity therapy staff could only offer this at a maximum once a week. One patient, who previously required intensive therapy, progressed from a hoist transfer to a standing transfer. However, when therapy staff reviewed the patient after they were transferred to a RAAC bed, staff had used a hoist to transfer the patient and the improvements the patient had made with regard to their mobility whilst at the community hospital had deteriorated.
- Therapy staff informed us that they had access to relevant equipment including practice steps, parallel bars and slopes. At Bromyard Community Hospital, occupational therapists were also able to use the physiotherapy department. However, staff informed us that the areas could be difficult to keep de-cluttered. We observed that equipment was stored around the parallel bars.
- We noted that overhead tracking was not present in all areas and therapy staff told us that it could be difficult in some of the side rooms to use a hoist. However, if there were any difficulties hoisting a patient, they would ask for the patient to be moved to another bed.

Equality and diversity

- The trust had translation services in place. Staff were able to complete an interpreter request form on the trust intranet and request for the service to be provided by telephone or face-to-face.
- If patients required specific equipment, nursing staff and or therapy staff would organise this appropriately, for example to accommodate bariatric patients. Therapy staff informed us that a patient was recently admitted and therapy was adapted to meet their specific requirements, including the use of a tilt table and accessing specialist slings. At Ross Community Hospital, we observed one patient who would only mobilise wearing specific footwear. Staff had risk assessed this and put into place appropriate plans to accommodate the patient's wishes. Documentation we reviewed confirmed this and all staff we spoke to were aware of the patients' specific needs.
- This meant that the trust was able to take account of the needs of different people and implement appropriate arrangements.

Meeting the needs of people in vulnerable circumstances

- We saw the use of the 'Forget Me Not' dementia scheme at Bromyard Community Hospital. This included provision of a carer's pass, nine important things about me and 'this is me' document. This helped staff to meet the specific needs of patients living with dementia.
- Ward staff at the four community hospitals explained that they would communicate with the patients' own carers if the patient was living with learning disabilities. This allowed staff to be aware of any specific needs and adapt care and treatment as appropriate.
- Psychiatric care and support was difficult to access at the community hospitals. The ward manager at Ross Community Hospital explained that at times they insisted on patients being transferred to Hereford Hospital to receive an assessment. There had been four

examples since January 2015 where patients had been transferred to the acute site for psychiatric assessments, where appropriate care and treatment could then be provided.
- We observed a handover during which staff explained that one patient on the ward would become more anxious due to an increased number of people on the ward. This meant all staff were aware of the patients' needs and how to provide support to that patient.
- At Ross Community Hospital, we saw the use of the Jackie Pool activity level assessment tool. This set of tools allowed therapy staff to develop a profile for a patient of their likes, dislikes and interests. This aided planning of activities to support the patient. Therapy staff had received additional training to use the tool effectively. This meant therapy staff were able to take into account the needs of different patients.

Access to the right care at the right time

- As of the 09 July 2015, the bed occupancy for the community hospitals was 92% and there had been seven delayed transfers of care. The Dr Foster Hospital Guide 2012 identified that occupancy rates above 85% could start to affect the quality of care given to patients and the running of the hospital more generally. The trusts' bed occupancy rate had been, on average, around 10% higher than the national average however between January 2015 and March 2015, it had dropped below the national average.
- Nursing staff informed us that some patients were medically fit for discharge but were waiting for social care packages to be in place. For example, at the time of our visit, there were three out of 14 patients at Bromyard Community Hospital waiting for social care packages. We observed discussions during handover as to what actions were required by staff.
- Where possible, the trust transferred patients to a RAAC bed. This allowed for those patients who were medically fit but were waiting for a social care package to be discharged. However, physiotherapy was only able to attend once a week, therefore any patients requiring ongoing therapy support in the community did not always receive the level of support required.
- The identification of patients who could be transferred to a community hospital was completed by the complex discharge team at Hereford Hospital. Patients were transferred accordingly following assessment. If required, patients could be referred back to the acute setting. The ward manager at Ross Community Hospital informed us that there were around five patients a month referred back to the acute setting. However, incident data from April 2015 showed that only two patients from Ross Community Hospital had been transferred back to Hereford Hospital.
- Physiotherapy staff assessed the patient on the same day as admittance depending on the admittance time. If a patient was admitted at the weekend, the assessment would take place on a Monday, as physiotherapy support was not provided at the weekends.

Learning from complaints and concerns

- Patients and relatives that we spoke with informed us that they had no issues about their care.
- We saw that information was displayed in the form of posters and leaflets regarding 'comments, compliments, concerns and complaints'. These were easily accessible for patients and relatives if they were needed.
- Nursing staff and healthcare assistants at the four community hospitals had a good understanding of the complaints process and told us it was important to learn from complaints. They explained that they would try to resolve the patients' concern or complaint straight way and that this resulted in few formal complaints being raised.
- Formal complaints were investigated through the central team based at Hereford Hospital. Ward staff informed us that learning would be disseminated at staff meetings. The ward manager at Bromyard Community Hospital explained that as a result of a complaint, an audit was undertaken for three months on the completion of communication sheets.
- Minutes from ward meetings detailed lessons learnt from complaints specific to that ward, as and when they arose. This meant that although lessons were being learnt and actions taken, if the complaint also involved the acute site, these lessons were not always shared.

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.

We found that:

There was no detail strategy that define how the community inpatient services would be developed.

The arrangements for governance and performance management did not always operate effectively. There were inconsistent practices in place across the community hospitals and documents were in use that had not been ratified through the governance process.

Risks and issues described by staff corresponded to those reported and were understood by leaders. However, there was limited evidence of how the risks affected patient safety, care and treatment.

Leaders were clear of their roles and accountabilities, however, not all leaders took part in all aspects of service development.

There was mixed staff satisfaction. Staff did not always feel actively engaged and that they were part of one trust.

The approach to service delivery and improvement was reactive and focused on short-term issues. The sustainability of safe, quality care was not always fully understood to enable staff to identify improvements and take action.

Service vision and strategy

- The trust 2015/16 business plan identified service redesign and changing the traditional model of community hospital beds to support alternative pathways closer to patients' home. However, the trust confirmed that there was not a specific strategy that related to community hospitals. Senior management of the service unit explained that ideas had been discussed at how the hospitals could be developed, however this was in the early stages and no formal documentation had been drafted.
- Senior staff explained that there was a requirement to look at the need and utilisation of community hospitals to ensure services were met and the right staff were in place to provide the services.
- The vision for the future of Wye Valley NHS Trust was displayed in ward corridors with the trust board structure chart to ensure all staff and patients had access to this information.

Governance, risk management and quality measurement

- The risk register for the urgent care and care closer to home service unit had three risks that related to community hospitals. These included the lack of provision for adult psychiatric liaison in community hospitals, nurse staffing levels specific to Leominster Community Hospital and Bromyard Community Hospital and the inability to recruit to SHO posts. The risk relating to nurse staffing levels was identified as financial due to increased cost pressures and irregular use of registered nurses with appropriate competences. There was no identification of the potential effect on patients' safety, care and treatment.
- Staff at three of the community hospitals told us that they were worried about staffing levels. The ward sister at Hillside Intermediate Care Centre told us that falls were their biggest risk due to the configuration of the ward. The ward had three high-lo beds and used anti-slip socks and crash mats / mattresses on the floor if a patient had been identified as high risk. However it was felt by staff that additional high-lo beds would aid in the reduction in the number of falls reported. As of 22 September 2015, Hillside Intermediate Care Centre had eight falls in September 2015.
- The service unit manager was informative of the risks relating to the community hospitals and identified the main risks as recruitment of nurses, robust medical cover, and organisational capacity. They felt that they were unable to maximise opportunities because there were a lack of diagnostics and support for diagnostics. However, this last risk had not been identified on the risk register.
- We reviewed written notes from service unit governance meetings and noted that the head of nursing for community hospitals attended. The Unit Governance Group had a standard agenda, which encompassed quality and safety issues, including incidents and

serious incidents, clinical effectiveness and audit, medication errors, and the family, and friends test. Mortality and stroke were also agenda items. Senior staff confirmed that the service unit lead nurses also attended these meetings.

- We were informed that incidents and the learning from these were discussed at the monthly sisters meeting. Each month an incident was discussed as well as the learning and then cascaded during ward meetings. We were informed that learning from incidents was a standard agenda item on ward meetings. From the meeting minutes we reviewed, we noted that lessons learnt were not a standard agenda item and where lessons learnt were discussed, this was pertinent to the community hospital it happened in. There was no evidence of shared learning from other sites. This meant that there was no consistency in learning from incidents across the four community hospitals.
- The head of nursing for community hospitals informed us that they were automatically notified of any incidents that were rated as orange and red by the electronic reporting system and their governance department. This was in line with the trusts' incident management policy. This meant that if an incident required urgent attention or had the potential to be a serious incident immediate action could be taken.
- Ward meeting minutes at Bromyard Community Hospital evidenced discussions regarding the actions required following local audits of records, for example Waterlow scores and fluid balance charts. This data had been identified as part of the nursing safety indicator audits.
- Although regular spot check audits of nursing notes were undertaken, there was no formal process for the community hospitals to implement actions and learn lessons from these audits.
- We reviewed a copy of the pain chart used at Hillside Intermediate Care Centre and noted that it had been developed by another trust which had copyrights of the document. The ward manager confirmed that there was not a policy or standard operating procedure for the use of the document. We were informed that the document had not been ratified by the trust clinical governance process.
- We requested to see the results and action plans from the audit of nursing and medical falls risk assessments as indicated in the trusts audit programme. The trust informed us that nursing audits were completed across all inpatient sites; however no formal action plans had been developed as a direct result. The trust informed us that the outcomes of the audits were shared at local level by ward sisters. Additionally, we were informed that any patient fall that resulted in harm would have a full root cause analysis carried out; an action plan developed and monitored through the service unit improvement plans.

Leadership of this service

- Staff were knowledgeable about the 'Ask Richard' email address, which allowed staff to contact the chief executive officer, and they felt that they were freely able to use this service. Most staff were aware of the leadership of the trust and their service unit; however some trained nurses and healthcare assistants at Bromyard Community Hospital and Hillside Intermediate Care Centre were unaware of some senior nursing roles.
- The head of nursing of community hospitals informed us that they planned to work on site at the community hospitals one day a month. This would enhance the visibility of the role. We were informed that since the appointment of the lead nurses, there was a more robust nursing structure, which had improved communication between the ward sisters and the management team. We observed ward sisters at each community hospital speaking to staff to ensure everything was alright and whether there was anything that they required help with or additional support.
- Staff at all four community hospitals were aware of their own risks and explained what action they had taken to escalate these risks. Staff felt that the community sites worked well together, however one staff member told us that they did not feel trusted or respected by staff at Hereford Hospital. Another staff member told us that they felt the staff at Hereford Hospital were unaware of what services community hospitals could and could not provide. This meant that staff did not feel connected to the organisation as a whole.
- Ward sisters at each of the community hospitals worked clinically as well as in their managerial role. They informed us that they often had to work overtime to complete their managerial role or aspects of this role would not be completed. This meant that ward leaders had limited capacity to fulfil their leadership role effectively.

Requires improvement

Are services well-led?

- Physiotherapy staff informed us that board level communication was poor and that there was limited communication. Although an improvement had been noticed from the June 2014 Care Quality Commission inspection. They informed us that they were fairly self-sufficient and their line manager communicated through the use of email and visited every couple of months for a specific purpose. This meant that there was limited overall leadership for physiotherapy staff.

Culture within this service

- Staff spoke highly of their ward sister at each of the community hospitals and the ward sisters explained that they were proud of their team. At Bromyard Community Hospital, the ward sister explained that they were particularly proud of the way staff had worked together to get through recent difficulties, specifically when the hospital was informed that they would be closed.
- At Hillside Intermediate Care Centre, the ward sister felt that some staff had found it difficult to adjust to the changes since the hospital now focused on general rehabilitation and not specifically stroke rehabilitation. They went on to explain that there had been many changes and staff were suffering from change fatigue. Additional encouragement was being provided to staff to ensure culture within the hospital was not affected.
- At Ross Community Hospital, staff explained that there was an over reliance on Friends of Ross, a charitable group, in relation to the purchase of hospital equipment. This included a bladder scanner, beds, over-bed tables and televisions. The lead nurse went on to explain that they were unsure if Hereford Hospital were aware of the reliance on funding when requesting equipment. This meant that we were not assured that the trust was aware of the necessary requirements of the community hospitals to meet patient needs.

Public engagement

- Each community hospital carried out the friends and family test. With the exception of Ross Community Hospital, which achieved 94%, all community hospitals achieved 100% in August 2015 in relation to recommending the hospital to friends and family. This information was displayed at each of the community hospitals.
- The response rate for this test was also displayed and we noted that Hillside Intermediate Care Centre had a response rate of 100%, Bromyard Community Hospital and Ross Community Hospital had a response rate of 89% and Leominster Community Hospital had a response rate of 97%.
- At Bromyard Community Hospital, some of the comments were displayed outside the entrance to the ward and where appropriate what actions the ward had taken. One comment included, 'They have explained my treatment, they have agreed to leave my door open at night because I don't like it being closed'.
- Bromyard Community Hospital had been informed that the hospital was going to close. However, following further consultation and support from the local population other actions were put into place to ensure the hospital was staffed appropriately to provide safe care and treatment.

Staff engagement

- Ward staff and therapy staff were aware of the whistle-blowing process and who they would speak to. Nursing staff informed us that they would talk to their line manager and if no action was taken, they would escalate to more senior nurses.
- Physiotherapy staff at Bromyard Community Hospital had also been involved in a recent meeting that took place around the future of the hospital. They explained that various options had been discussed and they felt the hospital needed to focus on providing a general, good service to the local population.
- The lead nurse explained that following the focus group at Bromyard Community Hospital, they intended to do focus groups with staff at the remaining community hospitals to see what ideas staff had to take the community hospitals forward. However, this work had not yet taken place.
- At Hillside Intermediate Care Centre, local staff feedback sheets were in use and all staff were encouraged to complete them. The ward sister responded to each individually. They also allocated all staff a responsibility for the ward, for example being a link person, which encouraged everyone being a part of one team.
- Minutes from the ward meetings at Hillside Intermediate Care Centre noted that staff had asked to be able to input into the 'what the patient said' on the huddle board and to feedback positive and negative experiences. This meant staff were engaged in developing services as a result of feedback.

Requires improvement

Are services well-led?

- The ward sister at Hillside Intermediate Care Centre informed us that staff were not engaged or involved in the decision regarding the long term plans once stroke rehabilitation stopped. There was limited feedback to staff from other organisational inspections. For example, following the Patient-Led Assessment of the Care Environment (PLACE). There had also been no information to and involvement of staff into the necessary actions required following the last CQC inspection.
- The staff survey development action plan compared the 2014 service unit figures to the trust and NHS average. As of July 2015 operational actions had been identified, including to increase staff involvement in important service decisions. However the action plan had not been fully completed. This included absence of the identification of service leads against each action and the process for monitoring implementation

Innovation, improvement and sustainability

- The ward sister at Bromyard Community Hospital had done a recent presentation to the local clinical commissioning groups and GPs regarding the development of the hospital. This encouraged discussions around the potential of specialising in specific services and taking into account the needs of the local population.
- The head of nursing of community hospitals explained that staff were the key to future developments. Although they felt community hospitals were well staffed, further staff recruitment remained a problem, specifically around the location of the trust and marketing. They informed us that work was required on integrating community services and deciding upon the remit of a community hospital.
- The lead nurse explained that they would like to see an integrated approach in the community hospitals and introduce a band four practitioner to allow for progression for healthcare assistants. Although they needed to complete some research, an idea to improve the services was to train all staff to have the same basic skills and competencies within physiotherapy, occupational therapy and nursing. This would encourage continuity of care on a seven-day basis, and would potentially decrease a patient's length of stay in hospital.

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 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1) (2) (b) HSCA 2008 (Regulated Activities) Regulations 2014** **Good Governance** 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— **b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity** **The regulation was not being met because risks were not always identified and all mitigating actions taken. The governance structure in place did not always practice in line with trust policy.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014** **Staffing** 2. Persons employed by the service provider in the provision of a regulated activity must—

This section is primarily information for the provider

Requirement notices

a. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

The regulation was not being met because not all staff had had mandatory training, supervision and appraisals as required by the trust's policies.