Ripley Hospital

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Ripley Hospital is a small community hospital in Ripley, Derbyshire. There is one inpatient ward, Butterley, which provides rehabilitation services for up to 20 adults.

Patients were very positive about the caring way staff treated them. We observed staff using good communication skills to establish rapport with patients and build their trust. The Trust employed a range of specialist teams to support staff on inpatient units. These included continence nurse specialists, the falls team and speech and language therapists. There were plans for seven day working to cover all four local hospitals including Ripley, to provide a better service for patients.

Patients on the ward received integrated rehabilitation from an effective multidisciplinary team. The staff had developed opportunities to promote people's independence and emotional well-being. Patients' progress was monitored and reviewed and the staff team could access other professionals for advice as needed.

There were systems in place to monitor and report safety incidents including falls and pressures ulcers. There was a culture of learning as a result of incidents. Patients' care was centred on safety and preventing avoidable harm. Some medicines administration records were incomplete and had not been picked up in routine checks. Patient information was kept securely and the environment and equipment were appropriately maintained.

The discharge planning system on the ward was very effective. There was good engagement with other partners including social care. Managers were largely seen as supportive. Staff were confident that ward managers prioritised safe, high quality, compassionate care and escalated issues and concerns in an appropriate way. Not all staff felt valued by the Trust. Healthcare support workers felt in some cases their additional training and skills were not valued and that opportunities for progression were limited.

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

Safety incidents were monitored effectively and staff were well supported in delivering safe care. Staff completed suitable risk assessments and appropriate screening tools. In general care records were comprehensive, legible, organised and up to date, although some medicines administration records were not complete. The environment was recently purpose built and facilities were clean and maintained to an appropriate level of hygiene.

Are services effective?

There was good integrated rehabilitation supported by efficient multi-disciplinary working. Patients were encouraged to regain their independence. Outcomes were monitored and information shared effectively with different teams.

Are services caring?

Patients found staff were kind and caring. We observed staff treating patients with dignity and respect, using good communication skills. Staff recognised the importance of involving patients' relatives in plans for their discharge from hospital. Staff discussed treatment, therapy and discharge plans with patients and their relatives where appropriate. Most patients said they were involved in discussing their care plans and there was clear information about the ward for patients and relatives.

Are services responsive to people's needs?

Patients found staff were kind and caring. We observed staff treating patients with dignity and respect, using good communication skills. Staff recognised the importance of involving patients' relatives in plans for their discharge from hospital. Staff discussed treatment, therapy and discharge plans with patients and their relatives where appropriate. Most patients said they were involved in discussing their care plans and there was clear information about the ward for patients and relatives.

Are services well-led?

Managers were supportive and escalated staff concerns where appropriate. The Trust's senior management team were known to staff and communicated by email, bulletins and the intranet. There was a large photo display of the Trust Board on a wall in the hospital and this meant that patients also had access to this information. Staff had regular supervision and had appraisals to support their professional development. Some health care support workers felt their additional training and skills were not valued by the Trust, role development opportunities varied across the organisation.

Summary of findings

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

Community inpatient services

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Summary of findings

What people who use the community health services say

The Trust used the Friends and Family Test, which asks patients whether they would recommend the ward to their friends and family if they required similar care or treatment. The score for all inpatient facilities provided across the Trust put the Trust in the top 25% for England.

Patients told us they were very happy with their care at Ripley Hospital and thought it provided a very good service. They said staff were kind and helpful and kept them informed about what was going on.

Areas for improvement

Action the community health service SHOULD take to improve

- Ensure that medicines administration records are completed accurately.

Action the community health service COULD take to improve

- Provide professional development opportunities for healthcare support workers who undergo further training.

Good practice

- There was very good integrated rehabilitation taking place as part of people's care plans, supported by effective multi-disciplinary working.
- Staff developed a range of opportunities for patients to re-gain their independence.
- Discharge planning was very well managed and effective.

Ripley Hospital

Detailed findings

Services we looked at:
Community inpatient services

Our inspection team

Our inspection team was led by:

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

Head of Inspection: Ros Johnson, Care Quality Commission

The team included CQC inspectors, a nurse specialist and an expert by experience with personal experience of using or caring for someone who uses the type of service we inspected.

Background to Ripley Hospital

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

There is one inpatient ward, Butterley, which provides rehabilitation services for up to 20 adults.

Ripley Hospital has not previously been inspected by the CQC.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

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

- Community inpatient services

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the location. We carried out an

Detailed findings

announced visit on 27 February 2014. During our visit we spoke with staff in a number of different roles, spoke with patients and their relatives, observed people's care and treatment and reviewed personal care or treatment records. We reviewed information sent to us by patients and local people following a press release and publicity about our inspection. We also reviewed information from comment cards completed by people using the services.

Community inpatient services

Information about the service

Ripley Hospital is a small community hospital in Ripley, Derbyshire. There is one inpatient ward, Butterley, which provides rehabilitation services for up to 20 adults.

During our inspection we spoke with a range of staff on the ward, approximately five patients on the ward and reviewed information from comment cards that were completed by people using the services. We observed care and treatment in different areas of the ward and examined three people's care records.

Summary of findings

Patients were very positive about the caring way staff treated them. We observed staff using good communication skills to establish rapport with patients and build their trust. The Trust employed a range of specialist teams to support staff on inpatient units. These included continence nurse specialists, the falls team and speech and language therapists. There were plans for seven day working to cover all four local hospitals including Ripley, to provide a better service for patients.

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Community inpatient services

Are community inpatient services safe?

Safety in the past

There were mechanisms in place to monitor and report safety incidents such as falls and pressure ulcers. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Incident data were reported to the safety group and cascaded to staff. Staff told us they got feedback on safety incidents at weekly and monthly ward meetings. There was a notice board on the ward headed 'Safe Care Information' which was last updated 26 February 2014. This listed the number of preventable incidents, including pressure ulcers, as well as complaints.

Learning and improvement

All staff were actively encouraged to record incidents on the electronic reporting system. Health care assistants asserted they could do this themselves, and did not need to go through a manager. The ward sister was clear about the root cause analysis process, and how improvements to practice could be made as a result of the analysis. Staff were confident in approaches to pressure area care and the sister completed root cause analyses (RCA). Reports were sent to the tissue viability team, ward managers and the matron who then provided an oversight of the target times for improvement plans. Learning from root cause analysis of incidents was raised in weekly team meetings and reflective sessions on how to improve practice were led at these meetings by the matron.

Staff received regular feedback from divisional governance meetings. Lessons learned were shared at ward meetings and information was extracted from audits, the incident reporting system and information received through the 'Friends and Family test' comment cards and follow up interviews. Audits were undertaken of a sample of patient records every eight weeks, discussed through the matron and new practice reinforced. This has included demonstrating patient inclusion and involvement in their treatment plans and identifying where patients with learning disabilities may need extra support.

Systems, processes and practices

Overall there were effective and reliable systems in place to enable staff to deliver safe care. Staff completed suitable risk assessments and appropriate screening tools, as well as a significant events record. We looked at a number of patients' care records. Documentation centred on safety; care records were comprehensive, legible, organised and up to date. The ward staff followed clear criteria for reporting incidents and timescales for doing so.

The environment was recently purpose built and facilities were clean and maintained to an appropriate level of hygiene. Housekeeping staff were managed by the ward team and there were cleaning schedules for housekeeping and for nursing staff. A 'credit for cleaning audit' was carried out by ward managers and scores were passed up through the governance structure electronically to inform the frequency of audit needed. Equipment such as furniture and mobility equipment was checked regularly and equipment was maintained through a programme of works by medical engineers as needed. Staff reported that the engineers responded promptly to requests for repairs.

Monitoring safety and responding to risk

Staff told us that eight weekly records audits were carried out. These looked at a sample of patients' medical and nursing notes selected at random. These audits checked that risk assessments had been completed within the given timescale. Staff were aware that they had to record a reason if a timescale was missed. Audit findings and action plans for improvement were reported through the matron back to ward staff at all levels. We saw however that the administration of some medicines had not been signed off by two nurses as was required. One person's eye medication had not been administered on three consecutive occasions according to records. There was no indication on the record that this had been picked up by audit.

We saw from observations, examining care records and talking with staff and patients that care was focused around the patient and risks were identified and monitored appropriately.

Anticipation and planning

The Trust was a key partner in the local health economy's development of seven day services and promoting the delivery of extended service provision across the week. Derbyshire was one of the "Early Adopter" sites. As part of this the Trust was developing an Advanced Nurse Practitioner (ANP) role to work across both acute and community trusts supporting patients in acute and community care, in and out of hours. Ripley Hospital was the first to appoint an ANP to help ensure smooth handovers of care with the acute hospitals and liaise with

other specialist nurses. Staff described the ANP role as a 'big part of the team' providing a stable core for medical staff and developing relationships with GP's who came into the hospital three times each week.

Are community inpatient services effective?
(for example, treatment is effective)

Evidence-based guidance
We found good integrated rehabilitation taking place as part of people's care plans. This was supported by efficient multi-disciplinary working. Therapists on the ward ran a breakfast and a lunch club. Suitable patients were encouraged to make these meals in the occupational therapy kitchen, enhancing their skills in preparation for discharge. We saw group as well as individual physiotherapy sessions taking place. Patients were encouraged to dress and to use the lounge area during the day, rather than remain in bed. We saw craft sessions taking place. This all encouraged social interaction and confidence as well as mental stimulation.

We saw holistic assessments were carried out, looking at patients' emotional, social and physical care needs, to ensure appropriate treatment plans. Care plans were personalised and reflected the care patients were receiving. Healthcare support workers talked about rehabilitation as an integral part of their care work and therapists were evident on the ward and involved with discharge planning. Patients told us they received effective care and treatment.

Monitoring and improvement of outcomes
We saw arrangements in place to check that care and treatment was effective. Where screening tools were completed, findings were followed up by an appropriate professional where needed. Care plans were kept up to date. Staff in different roles told us how they communicated with each other about patients' progress and worked together as a team. Patients also reflected this when they spoke with us about the care they received.

Ward staff told us that specific information about patients' nutritional risks was handed over when they came on duty. Health care assistants fed back information to the nurse manager if a patient seemed to be struggling with eating and drinking. Two nurses on the ward were trained in assessing patients with swallowing difficulties, and made referrals to speech and language therapists. Although mealtimes were protected from general intrusion, relatives were encouraged to come in and help a patient to eat or to eat their meals with the patient if this was their custom and it supported the patient's nutrition.

Managers told us that they could make good use of sharing the building with outpatient services. Podiatry or hearing services referrals could be made by the ward. Consultants' teams could be booked in to visit a patient on the ward to avoid the patient being transported to the general or acute hospital for appointments.

Sufficient capacity
The ward was divided into two 'wings'. It was staffed by three staff nurses and three healthcare support workers during the morning, two staff nurses and three healthcare support workers during the afternoon and evening and at night by two staff nurses and two healthcare support workers. The ward was very busy with staff when we were there in the middle of the day but these included therapy staff.

Managers could access bank staff directly to cover for staff sickness or annual leave and we noted that there was one bank healthcare support worker on duty during the afternoon of our visit. The Matron divided her time between Ripley and another hospital and there was a ward manager on duty. There was also an advanced nurse practitioner (ANP) on duty but these staff did not appear on the written roster on display on the ward. The ANP had advanced skills in clinical decision making and prescribing. They were able to admit patients and carry out patients' daily reviews; they also took part in the weekly ward round with the doctor.

Patients told us they were happy with the staffing levels although one patent said they often had to wait up to ten minutes before their call bell was answered, which meant they had to wait for example to have help to use the toilet.

Multidisciplinary working and support
Staff planned and delivered treatment as an integrated team so as to support people to be as independent as possible. Physiotherapists and occupational therapists were involved with the ANP or ward manager in the daily 'Jonah' meetings on the ward. These meetings looked at each patient's progress towards their discharge date and identified any blocks in achieving timely discharge. Staff told us that this electronic prompt system worked well to

Community inpatient services

improve the patient flow and the efficiency of the service. Each Thursday a Jonah meeting was held with local social care managers to discuss patients whose discharge was being delayed for no medical reason and who needed to be able to go home with community care package support.

Are community inpatient services caring?

Compassion, dignity and empathy

Patients told us the staff were mostly very kind and behaved in a caring way. We observed staff treating patients with dignity and respect, using good communication skills. Patients were given privacy when receiving care on the ward. Staff recognised the importance of involving patients' relatives in plans for their discharge from hospital. They also understood the complexity of patient's perception of their own capacity to manage an independent life.

Involvement in care

We saw that staff, including therapy staff discussed treatment, therapy and discharge plans with patients and their relatives where appropriate. Patients received a ward welcome information pack and were provided with leaflets about self-care on discharge. Most said they were involved in discussing their care plans and others told us that they did not wish to be involved. There was clear information on the ward for patients and relatives, including visiting times and the number and roles of staff on duty.

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

Meeting people's needs

The Trust employed a range of specialist teams to support staff in the community and on inpatient units. These included continence nurse specialists, the falls team and speech and language therapists. There were plans for seven day working to cover all four local hospitals for admissions. The aim was to improve services for people and the cost effectiveness of staff, by enabling a more integrated service.

Access to services

People were able to go to Ripley Hospital for rehabilitation following illness or injury, such as a fall at home or suffering a stroke. They were referred from an acute hospital or by their GP for assessment. This meant that people did not have prolonged stays at an acute hospital and were able to stay closer to home. One person we spoke with had had a fall at home. Through a local falls partnership arrangement they had been brought by the ambulance service to Ripley Hospital instead of the acute hospital and were pleased to be receiving care and rehabilitation locally.

Leaving hospital

Patients and their carers were aware of their discharge plans and were involved in making sure they were successful. We saw therapists discussing their contribution to these arrangements with a patient and their spouse. The ward staff told us that the 'Jonah' discharge tool used by the Trust was very effective. We observed part of a daily discharge planning meeting, which was an opportunity to make sure the right equipment was in place and the correct professionals were involved in order for the patient to be sufficiently independent. This was an effective collaborative and multi-disciplinary meeting, to which all relevant professionals contributed so that shared priorities were set.

All patients were given a predicted date of discharge on admission, depending on their presenting condition. This could be extended as necessary, according to the patient's needs. We noted in the meeting that we observed that it was agreed with the ANP to put back the predicted discharge date for one patient because their progress through their treatment plan had become slower than expected. This demonstrated that predicted discharge dates were used as an important guide and not against the best interest of the patient. Patients whose discharge was delayed were highlighted by the tool and tasks were identified to ensure continued discharge planning. Patients at risk of delayed discharge were also highlighted so that progress could be monitored closely. This meant that gaps in service provision were identified to support the patient regain their independence.

There were weekly meetings with the ward manager, matron, general manager and community social care managers, shared with Babington Hospital. These meetings focused on moving patients through the system to prevent unnecessary delays to discharge. Top delays were escalated to divisional managers following these meetings so that barriers to discharge in the wider system could be addressed.

Community inpatient services

Learning from experiences, concerns and complaints

One patient told us they knew who to talk to if they had a concern but another patient told us that they did not. The Trust used the Friends and Family Test, which asks patients whether they would recommend the ward to their friends and family if they required similar care or treatment. The score for all inpatient facilities provided across the Trust averaged a high score of 88 during the period April to September 2013.

Are community inpatient services well-led?

Vision, strategy and risks

Staff told us senior managers and executives were visible in promoting the vision and values of the Trust. They saw them for example appearing in online video clips. Senior managers conducted 'walk arounds' and each Friday the Chief Executive Officer sent an email letter to all staff members talking about the part of the service she had visited that week. We noted that there was a large photo display of the trust board on a wall in the hospital and this meant that patients also had access to this information.

The last assessment by the NHS Litigation Authority (NHSLA) was in 2012. The NHSLA handles negligence claims made against NHS organisations and assesses the processes trusts have in place to improve risk management. The Trust was assessed at level 1 in 2012 which meant they had policies in place which described the actions staff were required to follow. We saw that staff were familiar with the incident reporting system, were able to access it without going through a manager and understood their responsibilities for risk management. They were confident that any incidents reported would be investigated.

Quality, performance and problems

Managers were largely seen as supportive; there were weekly staff meetings for nurses, heath care support workers and housekeeping staff and also monthly staff meetings for nurses. Staff were encouraged to raise concerns at these meetings. The ward sister told us that a programme of regular one to one meetings for staff in management roles was in place with their managers, and this was being developed in the near future for nurses and heath care support workers. All staff had an annual appraisal although some staff told us this was a formality and not always a useful event others told us that it was useful for identifying training needs to develop the ward and the team.

Clinical supervision was always available on request for nursing staff and these could take the form of group 'reflective' sessions to address the impact of incidents or particular challenges on staff. The role of the clinical facilitator also included ensuring that each staff member's training was up to date and that future training needs were identified. Staff told us that they valued this role highly. The advanced nurse practitioner attended county-wide team meetings, where role support and management structures were discussed.

Some staff did not feel valued by managers and health care support workers felt in some cases their additional training and skills were not acknowledged. They felt progression opportunities were limited, and that there were different approaches in the different geographical areas of the Trust.

Leadership and culture

We saw that leadership on the ward was visible. Staff reported that managers prioritised safe, high quality, compassionate care. Ward managers and sisters were seen by staff to escalate issues and concerns; they provided supportive supervision sessions and were all approachable. Staff told us about the 'Staff Zone' on the Trust's intranet site that provided feedback to staff on positive comments received about the service and training bulletins and news within the Trust.

Patient experiences and staff involvement and engagement

Staff told us they accessed the staff forum on the Trust's intranet, which could be used anonymously. This was well used and members of the executive team often responded in a supportive way. Staff were encouraged to raise concerns and the future development of the one to one meetings programme was seen a further way to make sure that staff could raise any concerns that they had about patient safety. A meeting for healthcare support workers was held recently for the first time; staff told us that they were able to raise their concerns about delegated tasks and clarity of their role.